SERFF Tracking Number:	*FEMC-127630947*	*State:*	*Arkansas*
Filing Company:	*Federated Life Insurance Company*	*State Tracking Number:*	*49821*
Company Tracking Number:			
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*LIFEPOL2012*		
Project Name/Number:	*LIFEPOL2012/GL 03 10 (01-12 ed.)*		

Filing at a Glance

Company: Federated Life Insurance Company

Product Name: LIFEPOL2012	SERFF Tr Num: FEMC-127630947	State: Arkansas
TOI: L04G Group Life - Term	SERFF Status: Closed-Approved-Closed	State Tr Num: 49821
Sub-TOI: L04G.500 Other	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Jeanette Myers	Disposition Date: 09/27/2011
	Date Submitted: 09/16/2011	Disposition Status: Approved-Closed
Implementation Date Requested: 01/01/2012		Implementation Date:

State Filing Description:

General Information

Project Name: LIFEPOL2012	Status of Filing in Domicile: Pending
Project Number: GL 03 10 (01-12 ed.)	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 09/27/2011	
State Status Changed: 09/27/2011	Deemer Date:
Created By: Jeanette Myers	Submitted By: Jeanette Myers

Corresponding Filing Tracking Number:

Filing Description:

Federated Life Insurance Company is submitting a group life policy and group life certificate for your review and approval. The submitted forms are new forms. The policies will be issued to employers in the small and large group markets.

The group life policy and group life certificate are identical except for the first page, therefore we are only submitting one set of the policy and certificate sections (Section I through Section 8) and two face pages with indexes.

While attached forms are submitted on 8 ½ by 11 paper, we may also print the same text in a booklet format (e.g. 5 ½ by 8 ½) or on electronic media (e.g. CD-ROM, Internet), if requested by the policyholder. The type font may change but

the font-size will remain at least 10pt. We may also issue certificates in a foreign language, based upon a direct translation of the filed wording.

Company and Contact

Filing Contact Information

Jeanette Myers, Compliance Analyst
121 East Park Square
Owatonna, MN 55060

jmmyers@fedins.com
800-533-0472 [Phone]
507-455-8226 [FAX]

Filing Company Information

Federated Life Insurance Company
121 East Park Square
PO Box 328
Owatonna, MN 55060
(800) 533-0472 ext. [Phone]

CoCode: 63258
Group Code: 7
Group Name:
FEIN Number: 41-6022443

State of Domicile: Minnesota
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$550.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Federated Life Insurance Company	$550.00	09/16/2011	51704298

SERFF Tracking Number:	*FEMC-127630947*	*State:*	*Arkansas*
Filing Company:	*Federated Life Insurance Company*	*State Tracking Number:*	*49821*
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TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*LIFEPOL2012*		
Project Name/Number:	*LIFEPOL2012/GL 03 10 (01-12 ed.)*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/27/2011	09/27/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Linda Bird	09/21/2011	09/21/2011	Jeanette Myers	09/27/2011	09/27/2011

SERFF Tracking Number:	*FEMC-127630947*	*State:*	*Arkansas*
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Disposition

Disposition Date: 09/27/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FEMC-127630947*	*State:*	*Arkansas*
Filing Company:	*Federated Life Insurance Company*	*State Tracking Number:*	*49821*
Company Tracking Number:			
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*LIFEPOL2012*		
Project Name/Number:	*LIFEPOL2012/GL 03 10 (01-12 ed.)*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document *(revised)*	Flesch Certification		Yes
Supporting Document	Flesch Certification	Replaced	Yes
Supporting Document	Application		Yes
Form *(revised)*	Policy Cover Page		Yes
Form	Policy Cover Page	Replaced	Yes
Form *(revised)*	Certificate Cover Page		Yes
Form	Certificate Cover Page	Replaced	Yes
Form	General Provisions		Yes
Form	Enrollment & Effective Date		Yes
Form	Termination of Coverage		Yes
Form	Extension of Coverage & Conversion		Yes
Form	Covered Events		Yes
Form	Exclusions		Yes
Form	Definitions		Yes
Form	Grievance & Appeal Procedures		Yes
Form	Schedule of Benefits		Yes

SERFF Tracking Number:	*FEMC-127630947*	*State:*	*Arkansas*
Filing Company:	*Federated Life Insurance Company*	*State Tracking Number:*	*49821*
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TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*LIFEPOL2012*		
Project Name/Number:	*LIFEPOL2012/GL 03 10 (01-12 ed.)*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/21/2011
Submitted Date	09/21/2011
Respond By Date	10/21/2011

Dear Jeanette Myers,

This will acknowledge receipt of the captioned filing.

Objection 1
Comment: Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 15-2009 further address this issue.

Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the provisions of this rule as well as all applicable requirements of this Department.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.
Sincerely,
Linda Bird

SERFF Tracking Number:	*FEMC-127630947*	*State:*	*Arkansas*
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TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*LIFEPOL2012*		
Project Name/Number:	*LIFEPOL2012/GL 03 10 (01-12 ed.)*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	09/27/2011
Submitted Date	09/27/2011

Dear Linda Bird,

Comments:

Response 1

Comments: GL 03 10 (01-12 ed.) and GL 03 11 (01-12 ed.) have been revised to add the required information below the indexes. A certfication is also attached.

Related Objection 1

Comment:
Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 15-2009 further address this issue.

Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the provisions of this rule as well as all applicable requirements of this Department.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Flesch Certification
Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Policy Cover Page	GL 03 10 (01-12 ed.)		Policy/Contract/Fraternal Certificate	Initial			GL 03 10 _01-12 ed._.pdf
Previous Version							
Policy Cover Page	*GL 03 10 (01-12*		*Policy/Contract/Fraternal Certificate*	*Initial*			GL 03 10 _01-12

SERFF Tracking Number:	*FEMC-127630947*	*State:*	*Arkansas*
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Company Tracking Number:			
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*LIFEPOL2012*		
Project Name/Number:	*LIFEPOL2012/GL 03 10 (01-12 ed.)*		

	ed.)				ed._.pdf
Certificate Cover Page	GL 03 11 (01-12 ed.)	Certificate	Initial		GL 03 11 _01-12 ed._.pdf
Previous Version					
Certificate Cover Page	*GL 03 11 (01-12 ed.)*	*Certificate*	*Initial*		GL 03 11 _01-12 ed._.pdf

No Rate/Rule Schedule items changed.

Thank you.

Sincerely,
Jeanette Myers

SERFF Tracking Number:	*FEMC-127630947*	*State:*	*Arkansas*
Filing Company:	*Federated Life Insurance Company*	*State Tracking Number:*	*49821*
Company Tracking Number:			
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*LIFEPOL2012*		
Project Name/Number:	*LIFEPOL2012/GL 03 10 (01-12 ed.)*		

Form Schedule

Lead Form Number: GL 03 10 (01-12 ed.)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	GL 03 10 (01-12 ed.)	Policy/Contract/Fraternal Certificate	Policy Cover Page	Initial			GL 03 10 _01-12 ed._.pdf
	GL 03 11 (01-12 ed.)	Certificate	Certificate Cover Page	Initial			GL 03 11 _01-12 ed._.pdf
	GL 00 01 (01-12 ed.)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	General Provisions	Initial			GL 00 01 (01-12 ed.).pdf
	GL 00 02 (01-12 ed.)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Enrollment & Effective Date	Initial			GL 00 02 (01-12 ed.).pdf
	GL 00 03 (01-12 ed.)	Policy/Contract/Fraternal Certificate: Amendment, Insert	Termination of Coverage	Initial			GL 00 03 (01-12 ed.).pdf

		Page, Endorsement or Rider			
GL 00 04 (01-12 ed.)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Extension of Coverage & Conversion	Initial		GL 00 04 (01-12 ed.).pdf
GL 00 05 (01-12 ed.)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Covered Events	Initial		GL 00 05 (01-12 ed.).pdf
GL 00 06 (01-12 ed.)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Exclusions	Initial		GL 00 06 (01-12 ed.).pdf
GL 03 07 (01-12 ed.)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorseme	Definitions	Initial		GL 03 07 _01-12 ed._.pdf

SERFF Tracking Number:	*FEMC-127630947*		*State:*	*Arkansas*	
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Company Tracking Number:					
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Product Name:	*LIFEPOL2012*				
Project Name/Number:	*LIFEPOL2012/GL 03 10 (01-12 ed.)*				
	nt or Rider				
GL 00 08 (01-12 ed.)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Grievance & Appeal Procedures	Initial		GL 00 08 (01-12 ed.).pdf
GL 00 20 (01-12 ed.)	Schedule Pages	Schedule of Benefits	Initial		GL 00 20 (01-12 ed.).pdf

FEDERATED LIFE

INSURANCE COMPANY
HOME OFFICE: 121 East Park Square, Owatonna, Minnesota 55060
Phone: 800-533-0472

GROUP LIFE POLICY

Policyholder: _____

_____

_____

Policy Effective Date: _____
at 12:01 a.m. Central Standard Time

Policy Anniversary: _____ and annually each year thereafter.

Policy Number: _____

This policy is delivered in Arkansas and is governed by its laws.

CONSIDERATION. The **policy** is issued to the **policyholder** in consideration of the application and payment of premiums.

Secretary President

INDEX

SCHEDULE OF BENEFITS

Section I - GENERAL PROVISIONS . . . . . GL 00 01 (01-12 ed.)

Section II - ENROLLMENT AND EFFECTIVE DATE. . . . . GL 00 02 (01-12 ed.)

Section III - TERMINATION OF COVERAGE . . . . . GL 00 03 (01-12 ed.)

Section IV - EXTENSION OF COVERAGE AND CONVERSION . . . . . GL 00 04 (01-12 ed.)

Section V - COVERED EVENTS . . . . . GL 00 05 (01-12 ed.)

Section VI – EXCLUSIONS. . . . . GL 00 06 (01-12 ed.)

Section VII – DEFINITIONS . . . . . GL 03 07 (01-12 ed.)

Section VIII - GRIEVANCE AND APPEAL PROCEDURES. . . . . GL 00 08 (01-12 ed.)

POLICYHOLDER SERVICES CONTACT INFORMATION

Federated Life Insurance Company
Attn: Group Administration
PO Box 328
Owatonna, MN 55060

800-377-9154

If we at Federated Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201
(501) 371-2640 or (800) 852-5494

FEDERATED LIFE

INSURANCE COMPANY

121 East Park Square ▪ Owatonna, MN 55060

GROUP LIFE INSURANCE CERTIFICATE OF COVERAGE

Employee:
IDN:
Coverage:
Death Benefit
Effective Date:
Employer:
Group No.:

POLICY NUMBER:
POLICYHOLDER:

The **policy** is delivered in Arkansas and is governed by its laws.

The insurance is effective on the date shown above, provided the **employee** meets the eligibility requirements of the **policy**. Only the **dependents** who meet the eligibility requirements of the **policy** are covered by the **policy**. **Dependents** not meeting eligibility are not covered.

The principal provisions of the **policy** are set forth in the following pages. This certificate is not the **policy**. It replaces any other certificate previously issued to the **employee** under the above **policy** number. The terms and conditions of the **policy** control the coverage provided.

Words and phrases appearing in **bold** type throughout the certificate have special meaning as set forth in the Definitions (form GL 03 07).

Executed by Federated Life Insurance Company at Owatonna, Minnesota.

SECRETARY **PRESIDENT**

INDEX

SCHEDULE OF BENEFITS

Section I - GENERAL PROVISIONS . . . . . GL 00 01 (01-12 ed.)

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Section V – COVERED EVENTS. . . . . GL 00 05 (01-12 ed.)

Section VI – EXCLUSIONS . . . . . GL 00 06 (01-12 ed.)

Section VII – DEFINITIONS . . . . . GL 03 07 (01-12 ed.)

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1200 West Third Street
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(501) 371-2640 or (800) 852-5494

SECTION I - GENERAL PROVISIONS

Various provisions in this document restrict coverage. Read the entire document carefully to determine rights, duties and what is and is not covered.

The words "**we**", "**us**" and "**our**" refer to Federated Life Insurance Company.

The word "**policyholder**" means the organization or **employer** listed as such on the face page.

Other words and phrases appearing in **bold** type have special meaning. Refer to Section VII - Definitions.

MALE PRONOUN. The male pronoun as used herein will be deemed to include the female.

1. **BENEFITS**

   We agree to pay **benefits** as provided in the **policy** to **covered persons** or **beneficiaries**.

2. **POLICY** CHANGES

   Changes may be made in the **policy** only by **us** acting through **our** President, Secretary, or Assistant Secretary. No agent may change or waive any terms of the **policy**.

3. ENTIRE CONTRACT

   The entire contract will be made up of the **policy**, the application of the **policyholder**, the applications of the **employers** and the applications of **covered persons**. All references to statements, applications, writings, and signatures as they apply to the terms of the **policy** will include their representations in electronic form, as agreed to by both **us** and the **covered person**, **employer**, or **policyholder** who made the statement, application, writing or signature.

4. INSURANCE DATA

   The **employer** will give **us** all of the data that **we** need to calculate the premium and all other information that **we** may reasonably require. **We** have the right to examine the **employer's** records relative to the **policy** at any reasonable time while the **policy** is in effect. **We** also have this right until all rights and obligations under the **policy** are finally determined.

5. STATEMENTS NOT WARRANTIES

   All statements made by the **policyholder** or **employer** or **covered person** will, in the absence of fraud, be deemed representations and not warranties. No statement made by the **policyholder** or **employer** or **covered person** to obtain coverage will be used to avoid or reduce the coverage unless it is made in writing and is signed by the policyholder or **employer** or **covered person** and a copy is sent to the **policyholder** or **employer** or **covered person** or his **beneficiary**.

6. MISSTATEMENT

   If information in the application of a **covered person** has been misstated, the corrected age and facts will be used to determine whether insurance is in force under the **policy** and in what amount. If insurance remains in force and an equitable adjustment of premium may be made.

7. RIGHT TO CONTEST

   We have no right to contest the coverage of an **employer** on the basis of any statement made in the **employer's** application after the **employer's** coverage has been in force for two years. Before then **we** have the right to contest only if the statement was in writing on a form signed by the **employer** and a copy of it is given to the **employer.** Coverage will only be rescinded for fraud or intentional misrepresentation of a material fact made by the **employer** in his application. Nothing in this provision shall keep **us** from using at any time a defense based on **policy** provisions that relate to eligibility for coverage.

   We have no right to contest the coverage of a **covered person** on the basis of any statement made in a **covered person's** application after the **covered person's** coverage has been in force for two years. Before then **we** have the right to contest only if the statement was in writing on a form signed by the **covered person** and a copy of it is given to the **covered person** or his **beneficiary**. Coverage will only be rescinded for fraud or intentional misrepresentation of a material fact made by the **covered person** in his application. Nothing in this provision shall keep **us** from using at any time a defense based on **policy** provisions that relate to eligibility for coverage.

8. NOTICE OF CLAIM

Written notice of claim must be given to **us** within 30 days after the occurrence or commencement of any loss covered by the **policy**, or as soon thereafter as is reasonably possible. Notice if given by or on behalf of the **covered person** to **us** at 121 East Park Square, Owatonna, MN 55060, or to any of **our** authorized agents, with information sufficient to identify the **covered person**, shall be deemed notice to **us**.

9. CLAIM FORMS

Upon receipt of a notice of claim, **we** will furnish to the **covered person** or **beneficiary** forms for filing proof of loss. If such forms are not furnished within 15 days after **we** receive the notice of claim, the **covered person** or **beneficiary** shall be deemed to have complied with the requirements of the **policy** regarding proof of loss, if within 90 days, the **covered person** or **beneficiary** gives **us** written proof covering the occurrence, the character and the extent of the loss for which claim is made.

10. PROOF OF LOSS

Written proof of loss must be furnished to **us** within 90 days after the date of loss. Failure to furnish such proof within 90 days shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, shall the proof of loss be submitted more than one year from the time proof is otherwise required.

11. TO WHOM PAYABLE

All **benefits** for **death** or **accidental death** are payable to the **covered person's beneficiary** of record on the date of **death**. If no **beneficiary** is designated or survives the **covered person**, **benefits** will be paid to the estate of the **covered person** or at **our** option to a close relative of the **covered person**. If the **beneficiary** cannot be located or does not exist, **benefits** will be paid to the estate of the **covered person** or at **our** option to a **close relative** of the **covered person**.

If any person to whom **benefits** are payable is a minor or, in **our** opinion, is not able to give valid receipt for any payment due him, such payment will be made to his **legal guardian** or **legal custodian**. If no **beneficiary** is designated or survives, up to $500 of the **benefit** can be paid to any person who incurred costs for funeral expenses or the last illness of the **covered person**.

All **benefits** for dismemberment are payable to the **covered employee**.

Payment in the manner described above will release **us** from all liability to the extent of any payment made.

12. TIMING OF **BENEFIT** PAYMENTS

Benefits are payable within 30 calendar days of the date **we** receive a proof of loss. If additional information is needed to process a claim, a request will be sent to the **covered person** or **beneficiary** within 30 calendar days. Interest will be paid as required by law on **benefits** payable. However, interest will not be paid for more than one year unless required by law.

13. PHYSICAL EXAMINATIONS AND AUTOPSY

We, at **our** expense, shall have the right and opportunity to examine the **covered person** when and as often as **we** may reasonably require during the pendency of a claim and to make an autopsy in case of **death** where it is not forbidden by law.

14. CHANGE OF **BENEFICIARY**

Unless the **covered person** makes an irrevocable designation of a **beneficiary**, the right to change the **beneficiary** is reserved to the **covered person**. The consent of the **beneficiary** or **beneficiaries** shall not be requisite to surrender or assignment of the **policy** or to any change of **beneficiary** or **beneficiaries**, or to any other changes in the **policy**.

15. LEGAL ACTIONS

No action at law or in equity will be brought to recover on the **policy** until at least 60 days after completion of all appeals as outlined in Section VIII - **Grievance** and Appeal Procedure. No action will be brought at all unless brought within 3 years after the time within which the appeals are complete.

16. **PHYSICIAN** / PATIENT RELATIONSHIP

The **covered person** will have the right to choose any **physician** who is practicing legally. **We** will in no way disturb the **physician** / patient relationship.

17. CERTIFICATES

At **our** option **we** will issue to the **employer** for delivery to each **covered employee** an individual certificate or **we** will deliver to each **covered employee** an individual certificate. The certificate will show the **benefits** provided under the **policy** and to whom **benefits** will be paid. Nothing in the certificate will change or void the terms of the **policy**.

18. SEVERABILITY

Any provision of the **policy** that is prohibited by law shall be void and be without force or effect. But this will not invalidate the enforceability of any other term, condition or provision of the **policy**.

19. PREMIUMS

a. PREMIUM PAYMENT. The premium for each **covered person** will be due prior to the first day of each month. All premiums are payable in advance by the **employer** at **our** Home Office or to **our** designated premium collection agent. All premiums must be made payable to "Federated Life Insurance Company". **Our** insurance agents are not authorized to collect premiums other than the first premium.

b. MONTHLY PREMIUM STATEMENT. A monthly premium statement will be prepared prior to the premium due date. This monthly premium statement will show the premium due and will reflect any pro rata premium charges and credits due to changes in the number of **covered persons** and changes in coverage that took place in the preceding month.

c. CHANGES IN PREMIUM RATES. **We** may change any premium rate from time to time with at least 31 days advance written notice. No change in rates will be made until 12 **months** after the date an **employer** purchases the **policy**.

However, **we** may change rates immediately only if, in **our** opinion, **our** liability is altered:

i. by any change in state or federal law; or

ii. by a revision in the insurance under the **policy** including but not limited to changes of over 20% in the number of **covered persons** with any one **employer**.

Any such change in rates will take effect on the effective date of the change in law or change in the insurance.

If an increase in rates takes place on a date that is not a premium due date, a pro rata premium will be due on the date of the increase. The pro rata premium will apply for the increase from the date of the increase to the next premium due date. If a decrease in rates takes place on a date that is not a premium due date, a pro rata credit will be granted. The pro rata credit will apply for the decrease from the date of the decrease to the next premium due date.

d. GRACE PERIOD. If, before a premium due date, the **employer** has not given written notice to **us** that the coverage for the **employer** is to terminate, a grace period of 31 days will be granted for the payment of each premium after the first premium. The coverage will stay in force during that time. If **we** do not receive the premium payment by the end of the grace period, the coverage will automatically terminate at the end of the grace period. However, if the **employer** has given written notice in advance of an earlier date of termination, the insurance will terminate as of the earlier date. The **employer** will be liable to **us** for any unpaid premium for the time the coverage was in force including the grace period.

e. INCORRECT PREMIUM PAYMENT. Premiums paid in error for a person who is not eligible to be insured, or for a person after his insurance has terminated, will be refunded without interest when requested by the **employer**. These premiums will not be refunded for more than the month in which **we** are notified of the termination of coverage.

f. NON-PARTICIPATING PREMIUM REFUNDS. The **policy** does not share in **our** surplus earnings.

20. DESIGNATION OF **BENEFICIARY**

The **covered employee** has the right to designate the **beneficiary** for **benefits** payable at his **death**. The initial **beneficiary** will be designated on the application for coverage. Changes of the **beneficiary** must be:

a. in writing; and

b. signed and dated by the **covered person**; and

c. received and recorded by **us**.

If 2 or more **beneficiaries** are named, the **covered employee** may assign them each an interest in the **benefits**. If no interest is assigned, all **beneficiaries** will share equally in the **benefits**.

Any change of **beneficiary** takes effect on the **calendar day** it is signed but only if it is received and recorded by **us**. Any change of **beneficiary** that is not received and recorded by **us** is not effective. The **covered employee** may not designate the **employer** as **beneficiary**. If the **policy** is converted to an individual **policy** under Section IV - Extension of Coverage & Conversion, 4. Conversion Privilege, the **beneficiary** will remain the same as on the group coverage unless specifically changed by the **covered employee**. Any **beneficiary** designated on a conversion **policy** will also be designated on the group **policy** if it remains in effect or is reinstated. Any designation of **beneficiary** on the conversion **policy** takes effect on the **calendar day** it is signed but only if it is received and recorded by **us**. Any designation of **beneficiary** on the conversion **policy** that is not received and recorded by **us** is not effective.

For **covered persons** who are not **covered employees** the **beneficiary** is the **employee**. **Covered persons** other than **covered employees** may not change the **beneficiary**.

21. ASSIGNMENT OF **POLICY**

The **covered person** may assign all of his ownership right, title, and interest under the **policy**. If such assignment is irrevocable, it shall irrevocably transfer all rights and privileges under the **policy** to the assignee. These rights include but are not limited to the right:

a. of conversion;

b. to change the **beneficiary**; and

c. to continue or to discontinue coverage.

We must receive the assignment in writing. It must be signed and dated by the **covered person** and consented to by **us**. **We** are not responsible for the validity or result of any assignment. Unless otherwise provided in the assignment, the interest of any revocable **beneficiary** shall come after the interest of any assignee, whether the assignment was made before or after the designation of **beneficiary**. Collateral assignments, by whatever name called, will not be permitted.

SECTION II - ENROLLMENT & EFFECTIVE DATE

Words and phrases appearing in bold type have special meaning as set forth in Section VII - Definitions.

1. **EMPLOYER** ENROLLMENT

   An **employer** shall apply to become a covered **employer** or **policyholder**. The **employer** will become a covered **employer** or **policyholder** on the first day of the **month** coinciding with or following the date such **employer** applies subject to:

   a. Approval by **us**; and

   b. Meeting the participation requirements shown below; and

   c. Meeting the contribution requirements shown below.

2. PARTICIPATION REQUIREMENTS

   a. When the **employer** pays the entire premium:

      If the **employer** is paying the entire premium for each **covered employee**, 100% of the eligible **employees** not covered under a separate unrelated employer's plan must be enrolled for coverage at all times.

      If the **employer** is paying the entire premium for each covered **dependent**, 100% of the eligible **dependents** not covered under a separate unrelated employer's plan must be enrolled for coverage at all times.

   b. When **covered employees** contribute to the premium payment:

      If **covered employees** contribute to the premium payment for their own coverage, a minimum of 85% of all eligible **employees** not covered under a separate unrelated employer's plan must be enrolled at all times.

      If **covered employees** contribute to the premium payment for their **dependents'** coverage, a minimum of 85% of all eligible **dependents** not covered under a separate unrelated employer's plan must be enrolled at all times.

   c. In addition, a minimum of two (2) eligible **employees** must always be insured under each **employer's** plan in order for coverage to be issued or continued.

3. CONTRIBUTION REQUIREMENTS

   When an **employer** does not pay the full premium for **covered employees** and **dependents**, the **employer** must:

   a. Pay a minimum of 70% of the premium for **covered employees**; or

   b. Pay a minimum of 35% of the total premium for **covered employees** and **dependents**.

4. **EMPLOYEE** ELIGIBILITY

   a. An **employee** is eligible for coverage under the **policy** if he:

      i. is **actively at work** and:

      ii. has completed the **waiting period** shown in the **employer's** application for coverage or was covered under the **employer's** prior plan on the day before the effective date of the **employer's** coverage with **us**; and

      iii. has submitted **proof of good health**.

   b. An **employee** is only eligible for **dependent** coverage if he elects **employee** coverage.

   c. Once enrolled, an **employee** is eligible for coverage under the **policy** only if he is **actively at work**.

5. **DEPENDENT** ELIGIBILITY

   a. **Dependents** are eligible for coverage under the **policy** if:

      i. They meet the definition of a **dependent** in Section VII - Definitions; and

      ii. The **employee** is covered by the **policy**; and

      iii. The additional premium for **dependent** coverage is paid; and

      iv. They have submitted **proof of good health**.

   b. Once enrolled, a **dependent** is eligible for coverage under the **policy** only if he meets the definition of a **dependent** in Section VIII – Definitions.

6. **EMPLOYEE** EFFECTIVE DATE

   a. Each eligible **employee** may elect coverage by completing and signing an application. The effective date of his coverage depends upon the date on which the **employee** elects the coverage.

      i. If elected on or before the date he becomes eligible, his coverage will be effective on the first day of the **month** after he becomes eligible.

      ii. If elected within 31 days after he becomes eligible, his coverage will be effective on the first day of the **month** after election.

      iii. If elected more than 31 days after he becomes eligible, his coverage will be effective on the first day of the **month** after **we** approve his application for coverage.

      iv. If his coverage ceased because he cancelled his payroll deduction, and he again elects to be insured, his coverage will be effective on the first day of the **month** after **we** approve his application for coverage.

   b. The **employee** must be **actively at work** on the effective date of his coverage for coverage to take effect.

   c. The **employee** must be **actively at work** on the effective date of any increase in his coverage for such increase in coverage to take effect.

   d. Decreases in coverage will take effect even if the **employee** is not **actively at work**.

7. **DEPENDENT** EFFECTIVE DATE (other than newborn or adopted children)

   a. Each **covered employee** may elect **dependent** coverage by completing and signing an application. The effective date of coverage for each **dependent**, except newborn or adopted children, depends upon the date on which the **employee** elects coverage for that **dependent**.

      i. If elected on or before the date the **employee** becomes eligible, the coverage for each **dependent** will be effective on the first day of the **month** after the **employee** becomes eligible.

      ii. If elected within 31 days after the **employee** becomes eligible, the coverage for each **dependent** will be effective on the first day of the **month** after election.

      iii. If elected more than 31 days after the **employee** becomes eligible, the coverage for each **dependent** will be effective on the first day of the **month** after **we** approve his application for coverage.

      iv. If the **employee's dependent** coverage terminated because he cancelled his payroll deduction and he again elects to be insured, the coverage for each **dependent** will be effective on the first day of the **month** after **we** approve his application for coverage.

      v. If the **employee** acquires an additional **dependent**:

         (1) If elected on or before he becomes a **dependent**, coverage will be effective on the date he qualifies as a **dependent**.

         (2) If elected after the date he becomes a **dependent**, coverage will be effective on the first day of the **month** after **we** approve his application for coverage.

   b. If a **dependent** is no longer covered because his eligibility ended, he must re-enroll for coverage if he becomes eligible again. Coverage is not automatically reinstated for **dependents** that were previously covered.

   c. The **employee** must be **actively at work** on the effective date of **dependent** coverage for coverage to take effect.

d. If a **dependent** is **disabled** on the date coverage is to take effect, the coverage will not be effective until the 8th **calendar day** after the **disability** ends. If a **dependent** is **disabled** on the date a coverage increase is to take effect, the coverage increase will not be effective until the 8th **calendar day** after the **disability** ends. Decreases in coverage will take effect even if the **dependent** is **disabled**.

e. Coverage for a newborn or adopted child is effective as outlined in subpart 8 below.

8. NEWBORN OR ADOPTED CHILD EFFECTIVE DATE

The effective date of coverage will be as follows:

a. For a newborn child, coverage is effective on the 15th **calendar day** after birth. The **employee** must enroll the newborn for coverage within the first 31 days after the date of birth and pay the required premium in order to have coverage for the newborn.

b. For an adopted child, coverage is effective on the date of "placement for adoption" or 15th **calendar day** after birth whichever is later. The **employee** must enroll the adopted child for coverage within the first 31 days after the date of placement for adoption and pay the required premium in order to have coverage for the adopted child.

The term "placement for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of that child. The child's placement with the person terminates upon the termination of such legal obligation.

SECTION III – TERMINATION OF COVERAGE

Words and phrases appearing in bold type have special meaning as set forth in Section VII - Definitions.

1. The **employer's** coverage under the **policy** will terminate at the earliest of the following dates:
   a. the date the **employer** fails to make any premium payment when due;
   b. the date the **employer** fails to comply with the **employer** contribution rules;
   c. the date participation requirements are no longer met;
   d. the date the **employer** commits fraud or intentionally misrepresents a material fact;
   e. for association groups, the date the membership of an **employer** in the association ceases; or
   f. the date **we** elect to discontinue the **policy** as permitted by state and federal law.
2. An **employee's** coverage will terminate on the earliest of the following dates:
   a. the date the **employer's** coverage terminates;
   b. the date the **employee** is not eligible for coverage;
   c. the date the **employee** does not make required premium contributions;
   d. the date the **policy** terminates.
3. A **dependent's** coverage will terminate on the earliest of the following dates:
   a. the date the **employer's** coverage terminates;
   b. the date the **employee** is not eligible for coverage;
   c. the date the **employee** does not make required premium contributions;
   d. the date the premiums are not paid for **dependent** coverage;
   e. the date the **policy** terminates;
   f. the date the **dependent** no longer meets the definition of **dependent** in Section VIII – Definitions.
4. The **employer** has the right to terminate coverage by providing **us** with advance written notice of his intent. The notice must be sent to **us** at the following address.

   Group Administration
   Federated Life Insurance Company
   PO Box 328
   Owatonna, MN 55060

   Coverage will terminate on the last day of the **month** in which **we** receive the **employer's** written notice of intent to terminate.
5. An **employee** or covered **dependent** has the right to terminate coverage by providing his **employer** with advance written notice of his intent. The **employer** must then notify **us** at the following address.

   Group Administration
   Federated Life Insurance Company
   PO Box 328
   Owatonna, MN 55060

   or by calling 800-377-9154.

   An **employee's** or covered **dependent's** coverage will terminate on the last day of the **month** in which **we** receive the **employer's** notice of intent to terminate coverage for that **employee** or covered **dependent**.

6. GRACE PERIOD

If, before a premium due date, the **employer** has not given written notice to **us** that the coverage for the **employer** is to terminate, a grace period of 31 days will be granted for the payment of each premium after the first premium. The coverage will stay in force during that time. If **we** do not receive the premium payment by the end of the grace period, the coverage will automatically terminate at the end of the grace period. However, if the **employer** has given written notice in advance of an earlier date of termination, the insurance will terminate as of the earlier date. The **employer** will be liable to **us** for any unpaid premium for the time the coverage was in force including the grace period.

SECTION IV – EXTENSION OF COVERAGE AND CONVERSION

Words and phrases appearing in **bold** type have special meaning as set forth in Section VII - Definitions.

1. EXTENSION OF COVERAGE - TEMPORARY LAYOFF OR LEAVE OF ABSENCE

   If an **employee** is no longer **actively at work** due to a layoff or leave of absence, then coverage will be extended for **covered persons** for four (4) **months** if the **employer** continues to pay the premium.

   Leave of absence includes **employees** who are not **actively at work** due to a **disability**.

2. EXTENSION OF COVERAGE - **DISABILITY** under age 60 - **COVERED EMPLOYEES**

   a. If the **covered employee** becomes **disabled** before age 60, the **policy** will extend coverage for **death** as long as the **disability** continues. The covered **employee** must:

      i. provide **us** notice of the **disability** within 9 **months** of it beginning; and

      ii. continue to pay premiums; and

      iii. provide **us** with proof of **disability** within 3 **months** of each anniversary of the original notice of **disability**.

   b. No premium will be due for coverage for the **covered employee** after the **covered employee** has been **disabled** for 12 **months**.

   c. This extension of coverage will automatically stop at the earliest of the following dates:

      i. the date the **covered employee** is no longer **disabled**; or

      ii. the date the **covered employee** fails to cooperate with any physical examination under Section I - General Provisions, 13. Physical Examination & Autopsy; or

      iii. the anniversary of the last proof of **disability** received by **us**.

   d. The **covered employee** will be entitled to the conversion privilege if he is not **actively at work** within 31 days of this extension terminating.

   e. If the **covered employee** dies while this extension is in place, **we** must receive notice of the **death** and proof of **disability** until **death**. If this information is not received by **us** within 12 **months** of the **death**, no **benefits** are payable.

   f. The general provisions of the **policy** apply to this extension of coverage. Any reductions in coverage scheduled to take effect while the **employee** is covered by this extension will apply to coverage provided under this extension.

   g. This extension of coverage does not apply to **accidental death** or **dismemberment**.

3. EXTENSION OF COVERAGE - **DISABILITY** - COVERED **DEPENDENTS**

   If coverage is continued for a **covered employee** under 2. Extension of Coverage - **Disability** under age 60 - **Covered employees** above, coverage can be continued for **dependents** that are covered by the **policy**. In order for coverage to continue for **dependents**, the **covered employee** or **employer** must pay any premiums due for **dependent** coverage. Premiums will be due for coverage for **dependents** no matter how long the covered **employee** is **disabled**.

4. CONVERSION PRIVILEGE

   a. When an **employee's** coverage terminates, he may be eligible to be insured under an individual **policy** of life insurance (called the "Converted Policy"). **Dependents** are not eligible to convert. A "Converted Policy" will be issued by **us** only to an **employee** who is entitled to convert, and only if he applies in writing and pays the first premium for the "Converted Policy" to **us** within 31 days after the date his insurance terminates. The "Converted Policy" will take effect on the 32nd day after his coverage terminates. **Proof of good health** is not needed.

b. **EMPLOYEES** ENTITLED TO CONVERT. An **employee** is entitled to convert coverage for himself but only if:

   i. The **employee's** insurance terminated because he is no longer **actively at work**; or

   ii. The **employee** is no longer a member of an eligible class of **employees**; or

   iii. The **policy** is terminated for the **employer** and the **employee** was insured under the **policy** for at least 5 years; or

   iv. The **employee's** class is no longer eligible for coverage and the **employee** was insured under the **policy** for at least 5 years.

c. The converted **policy** will be an individual **policy** (other than a term policy) issued by **us**. The premium on the converted **policy** will be the customary rate for the form and amount of the **policy** for a person of the same age and the class of risk on the effective date. The converted **policy** will not include **accidental death**, **disability**, **dismemberment** or other supplementary benefits.

d. If the coverage terminates because the **employee** is no longer **actively at work** or is no longer a member of an eligible class of **employees**, the maximum **benefit** available for the converted **policy** will be the **benefit** available under the group coverage.

e. If the coverage terminates because the **policy** is terminated by the **employer** or the **employee's** class is no longer eligible for coverage, the **benefit** available for the converted **policy** will be the lesser of:

   i. the **benefit** for the **covered employee** on the group policy less any amount of group life insurance the person is eligible for within 31 days of the termination; or

   ii. $10,000.

f. If the **covered employee** dies during the 31-day period after his group coverage terminates, **we** will pay the maximum amount of **benefit** available under the converted **policy** as a claim on the group **policy**. No premium will be charged for the converted **policy** if the **covered employee** dies during this 31-day period.

g. If the **covered employee** dies while covered under an extension of coverage under Section IV. 1 or 2 above, no **death benefit** is payable on the converted **policy**.

SECTION V - **COVERED EVENTS**

Words and phrases appearing in **bold** type have special meaning as set forth in Section VII - Definitions.

If a **covered event** happens, **we** will pay **benefits** as provided in the **schedule**. Payment of **benefits** will be subject to any applicable provisions set forth in the **schedule**.

If the **covered event** is not listed in this section or is excluded in Section VI - Exclusions, that **covered event** is not covered and **benefits** are not payable under the **policy**.

Any **covered event** specifically listed is only covered by that specific listing and not any general listing of **covered event**s.

1. **DEATH**

   If a **covered person** dies while the **policy** is in force, **we** will pay the **beneficiary** or **beneficiaries** the **death benefit** shown in the **schedule**.

2. **ACCIDENTAL DEATH**

   If a **covered employee** dies as the direct result of an accident, **we** will pay the **beneficiary** or **beneficiaries** the **accidental death** benefit shown in the **schedule**. The **death** must occur within 90 calendar days of the accident in order to qualify for an **accidental death benefit**. **Covered persons** other than **employees** are not eligible for an **accidental death benefit**.

3. **DISMEMBERMENT**

   If a **covered employee** is **dismembered**, **we** will pay the **covered employee** the **dismemberment benefit** shown in the **schedule**. No more than one **dismemberment benefit** will be paid to any **covered employee**. The **dismemberment benefit** will not be paid if the **dismemberment** occurs within 5 calendar days of the **covered employee's death**. The **dismemberment** must occur within 90 calendar days of an accident in order to qualify for a **dismemberment benefit**. **Covered persons** other than **employees** are not eligible for a **dismemberment benefit**.

SECTION VI – EXCLUSIONS

Words and phrases appearing in **bold** type have special meaning as set forth in Section VII - Definitions.

The following exclusions apply to all coverages described in the **policy**. Coverage is not provided for and no **benefits** will be paid for:

1. Events not listed as **covered events** in Section V - **Covered Events.**

2. **Death**, **accidental death** or **dismemberment** occurring when a **covered person's** coverage was not in effect under the **policy**.

3. **Death**, **accidental death** or **dismemberment** for which a **proof of loss** is not submitted within 12 months of the event.

4. **Accidental death** or **dismemberment** caused by or arising out of acts of war, insurrection, rebellion, armed invasion or aggression.

5. **Accidental death** or **dismemberment** occurring while held, detained or imprisoned in a local, state or federal penal or correctional institution or while in the custody of law-enforcement officials. Persons on work release are not considered to be held, detained or imprisoned.

6. **Accidental death** or **dismemberment** caused by or related to, any intentionally self-inflicted bodily injury.

7. **Accidental death** or **dismemberment** caused or contributed to by the **covered person's** commission of or attempt to commit a felony.

8. **Accidental death** or **dismemberment** caused or contributed to by the **covered person** being engaged in an illegal activity.

9. **Accidental death** or **dismemberment** caused or contributed to by the **covered person** being under the influence of alcohol or any narcotic (unless prescribed by a **physician**).

10. **Dismemberment** caused by **illness** or **surgical** treatment of an **illness**.

11. **Accidental death** or **dismemberment** caused or contributed by travel or flight in any aircraft except as a fare-paying passenger on a scheduled flight on a licensed passenger airline.

12. **Accidental death** or **dismemberment** caused or contributed to by the **covered person's** commission of civil or criminal assault or battery.

13. **Accidental death** or **dismemberment** caused or contributed to by an infection except septic infection of and through a visible wound from an accident.

14. **Accidental death** or **dismemberment** while a **covered person** is on active duty in the Armed Forces including the National Guard.

SECTION VII – DEFINITIONS

Words and phrases appearing in **bold** type in the **policy** have special meaning as set forth below.

1. **Accident**

   means something unforeseen, unexpected, unusual, extraordinary or phenomenal, taking place not according to the usual course of things or events. **Accident** does not include events occurring while the **covered employee** is under the influence of alcohol or any narcotic (unless prescribed by a **physician**).

2. **Accidental Death**

   means **death** caused by an **accident**.

3. **Accidental Death Benefit**

   means the amount payable as **benefits** for the **death** of a **covered employee** caused by an **accident**.

4. **Active Work / Actively At Work**

   means an **employee** is performing all of the duties of the job with an **employer** for a minimum of 30 hours per week. An **employee** will be considered **actively at work** on:

   a. Any scheduled work day he is performing his regular duties for the **employer** at the **employer's** place of business or a location where his **employer** requires him to travel; or

   b. Any day of a paid vacation; or

   c. Any regularly scheduled non-working day, provided that the **employee** was at work on the last regular working day prior to that date.

5. **Authorized Representative**

   means the person designated by a **covered person** to contact **us** regarding a grievance. The designation must be in writing, specifically authorize contact with **us** regarding a grievance and be signed by the **covered person**.

6. **Beneficiary or Beneficiaries**

   means the person or organization designated as **beneficiary** by the **covered employee**. For **covered person**s who are not **employees**, **beneficiary** means the **covered employee**.

7. **Benefits**

   means the amount payable for **covered events** that qualify for coverage under the **policy**.

8. **Calendar Day**

   means the period starting at 12:01 a.m. Central Standard Time on any day and ending at midnight on that day.

9. **Close Relative**

   means:

   a. **Spouse**;

   b. **Covered person's** child, brother, sister, or parent.

10. **Covered Employee**

    means an **employee** who is eligible for coverage under the **policy**, has applied for coverage and for whom a premium is paid to **us**.

11. **Covered Event**

    means the **death**, **accidental death** or **dismemberment** of a **covered person**.

12. **Covered person** or **Covered persons**

    means an **employee** or **dependent** that is eligible for coverage under the **policy**, has applied for coverage and for whom a premium is paid to **us**.

13. **Death**

means the permanent cessation of all the **covered person's** vital functions and signs.

14. **Death Benefit**

means the amount payable as **benefits** for the **death** of a **covered person**.

15. **Dependent** or **Dependents**

means the following:

a. the **covered employee's spouse**; or

b. the **covered employee's** natural or legally adopted child (under age 26); or

c. a child (under age 26) for whom the **covered employee** or his **spouse** is the **legal guardian**; or

d. a step-child (under age 26) of the **covered employee**; or

e. a child (under age 26) covered under a valid qualified medical child support order (as the term is defined under Section 609 of the Employee Retirement Income Security Act (ERISA) and its implementing regulations) which is enforceable against a **covered employee** or the **covered employee's spouse**; or

f. a disabled **dependent**. A disabled **dependent** is someone who:

i. is a child under 15.b. or 15.c. or 15.d or 15.e above; and

ii. is age 26 or older; and

iii. is "disabled" which means they are incapable of self-sustaining employment by reason of mental retardation, **mental illness**, or physical handicap; and

iv. obtains the majority of his financial support from the **covered employee** or the **covered employee's spouse**; and

v. was "disabled" prior to age 26.

Disability does not include pregnancy. The **covered employee** must give **us** a written request for coverage of a disabled **dependent**. The request must include written proof that the **dependent** is "disabled" and must be approved by **us** in writing. **We** must receive the proof of disability within 31 days of the date an already enrolled **dependent** becomes eligible for coverage under this definition or when adding a **dependent** eligible under this definition. **We** reserve the right to periodically review the disability status of the **dependent**. After the first two years, **we** will not review the disability more frequently than once every **calendar year**.

A person who is a **covered employee** is not eligible as a **dependent** under any **policy** issued by **us**. No one can be considered a **dependent** of more than one **covered employee** under any **policy** issued by **us**. If both **spouses** are covered as **covered employees** under any **policy** issued by **us**, only one **spouse** shall be considered to have any eligible **dependents**.

16. **Disabled** or **Disability**

a. An **employee** will be considered **disabled** if because of an **illness** or injury:

i. He is unable to perform the basic duties of his occupation; and

ii. He is under the regular care of his **physician**.

b. A **dependent** will be considered **disabled** if because of an **illness** or injury:

i. He is unable to engage in the normal activities of a person of the same age, sex and ability; and

ii. He is under the regular care of his **physician**; and

iii. In the case of a **dependent** who normally works for wage or profit.

(1) he is not performing such work; and

(2) he is unable to perform the basic duties of his occupation.

17. **Dismemberment** or **Dismembered**

means:

a. complete and permanent severance of a hand through or above the wrist; or

b. complete and permanent severance of a foot through or above the ankle; or

c. entire and irrevocable loss of sight beyond remedy by surgical or other means.

18. **Dismemberment Benefit**

means the amount payable as **benefits** for **dismemberment** of a **covered employee**.

19. **Employee**

means someone who is actively at work in an **employer's** business. **Employee** does not include owners, shareholders or officers of the business who are not **actively at work** in the business. The **employee** must be reasonably compensated and his **employer** must report his earnings as required for Social Security. Temporary **employees**, consultants, advisors and other similar individuals do not qualify as **employees**.

20. **Employer**

means an **employer** who, in order to provide group health coverage to eligible **employee**s, purchased the **policy** or participates in a multiple employer trust that purchased the **policy**.

21. **Grievance**

means any dissatisfaction with the administration or claims practices of or provision of service by **us** which is expressed in writing by or on behalf of a **covered person**.

22. **Illness**

means any bodily disorder, disease or **mental illness**. This includes pregnancy.

23. **Legal Guardian**

means the person appointed by a court of competent jurisdiction who has been granted sole authority to provide for the care of another. **We** may demand production of legal orders or other documents sufficient to establish proof of legal guardianship.

24. **Mental Illness**

means a condition that manifests symptoms for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication, regardless of any underlying physical cause.

In determining whether or not a particular condition is a **mental illness**, **we** may refer to the edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association that is most current at the time the mental illness is diagnosed. Alcoholism, drug addiction or chemical dependency is not considered **mental illness**.

25. **Month**

means the period starting at 12:01 a.m. Central Standard Time on the 1st day of a given calendar **month** and ending at midnight on the last day of the calendar **month**.

26. **Physician**

means a licensed medical doctor acting within the lawful scope of his license. For **mental illness** services, **physician** includes a licensed psychologist.

27. **Policy**

means **policy** forms, amendments and riders that constitute the agreement regarding the **benefits**, exclusions and other conditions.

28. **Proof of Good Health**

means satisfactory proof, as determined by **us**, that the **employee** or **dependent** is acceptable for coverage.

29. **Schedule**

means the **Schedule** of Benefits attached to the **policy**.

30. **Spouse**

means a person legally married to a **covered person**.

31. **Surgical**

means procedures listed as surgery in the edition of the American Medical Association Current Procedural Terminology (CPT) book most current at the time of the surgery.

32. **Waiting Period**

means the period of time that must pass before coverage begins for an eligible **employee** or **dependent** who enrolls for the **policy**.

SECTION VIII - **GRIEVANCE** AND APPEAL PROCEDURES

Words and phrases appearing in bold type have special meaning as set forth in Section VIII - Definitions.

1. SUBMISSION OF **GRIEVANCES**

Initially **grievances** should be submitted to **our** [Medical Benefits & Services Appeals Department] at:

[Medical Benefits & Services Appeals]
[Federated Mutual Insurance Company]
[P.O. Box 328]
[Owatonna, MN 55060]
[Fax: 507-446-4723]
[E-mail: healthappeals@fedins.com]

After that review is completed, a second level **grievance** can be submitted to **our** [Medical Benefits & Services Appeals]. A **covered person** can also contact the local U.S. Department of Labor Office or insurance regulator in their state to submit a **grievance** or complaint.

A **covered person** or **beneficiary** can appoint an **authorized representative** to act on his behalf in pursuing a **grievance**. The appointment of an **authorized representative** for handling **grievances** must be in writing and signed by the **covered person** or **beneficiary**.

Initial **grievances** must be submitted within 180 calendar days of the event giving rise to the **grievance**. The event giving rise to the **grievance** can be a notice of benefit determination, a notice of rescission of coverage, an administrative action by **us** or the provision of another service by **us**. For a **grievance** related to a notice of benefit determination or a notice of rescission of coverage, the date of the event is printed on the notice. For a **grievance** related to an administrative action by **us**, the date of the event is the date **we** took the administration action. For a **grievance** related to the provision of another service by **us**, the date of the event is the date **we** provided the service.

Second level **grievances** must be submitted within 60 calendar days of the date printed on the written notice of the initial **grievance** decision.

2. INITIAL **GRIEVANCE** PROCEDURE

When an initial **grievance** is received by **our** [Medical Benefits & Services Appeals Department], the following procedure will be used.

a. Written acknowledgment of the **grievance** will be sent to the **covered person**, **beneficiary** and/or the **authorized representative** within 3 working days. This shall include the name, address and phone number of the person handling the **grievance** and information on how to submit written material.

b. The person reviewing the **grievance** will not be the same person who initially reviewed the claim. .

c. An investigation will be completed and a decision made within 30 calendar days.

d. Written notice of the decision will be sent to the **covered person** and/or the **authorized representative**. That notice shall include:

   i. The specific reason for **our** decision.

   ii. The specific policy provisions applicable to the **grievance**.

   iii. Any internal guidelines used in making the decision.

   iv. Information on how to file a second level **grievance** and the right to sue after internal **grievance** procedures are completed by **us**.

   v. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

   vi. In states where the **covered person** has a right to review by the state regulatory agency, information on how to obtain that review.

3. SECOND LEVEL **GRIEVANCE** PROCEDURE

A second level **grievance** is initiated by sending a request for review to:

[Medical Benefits & Services Appeals]
[Federated Mutual Insurance Company]
[P.O. Box 328]
[Owatonna, MN 55060]
[Fax: 507-446-4723]
[E-mail: healthappeals@fedins.com]

Or by calling [507-455-5200] or toll free [800-533-0472] and asking for the [Medical Benefits & Services Appeals Department].

Our [Medical Benefits & Services Appeals Department] will complete this review.

When a second level **grievance** is received by **our** [Medical Benefits & Services Appeals Department], the following procedure will be used.

a. Written acknowledgment of the **grievance** will be sent to the **covered person** and/or the **authorized representative** within 3 working days. This shall include the name, address and phone number of the person handling the **grievance** and information on how to submit written material.

b. The person reviewing the **grievance** will not be the same person who initially reviewed the claim.

c. An investigation will be completed and a decision made within 30 calendar days.

d. Written notice of the decision will be sent to the **covered person** and/or the **authorized representative**. That notice shall include:

   i. The specific reason for **our** decision.

   ii. The specific policy provisions applicable to the **grievance**.

   iii. Any internal guidelines used in making the decision.

   iv. Information on how to obtain copies of documents **we** have on the **grievance**.

   v. Information on the right to sue after internal **grievance** procedures are completed by **us**.

   vi. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

   vii. In states where the **covered person** has a right to review by the state regulatory agency, information on how to obtain that review.

4. RECORDKEEPING

We will maintain a record of all **grievances** filed and their resolution. The record will include the name of the **covered person**, date of the **grievance**, nature of the **grievance**, date of response/resolution and summary of the resolution. Copies of all **grievances**, investigative material and response letters will be kept with the **grievance** record. The **grievance** record will be maintained in the claims office for a minimum of 5 years.

Periodically, **we** will review the **grievance** record. This review will include analysis of the appropriateness of responses.

SCHEDULE OF BENEFITS

Words and phrases appearing in bold type have special meaning as set forth in Section VII - Definitions.

1. Payment of **benefits** is only available for the **covered events** marked as included below.

	Coverage Included
Death	[Yes]
Accidental Death (**employees** only)	[Yes]
Dismemberment (**employees** only)	[Yes]

2. Payment of **benefits** for **covered events** for **employees** are as follows:

	Amount
Death - under age 65	100% of **death benefit** shown on certificate face page
Death - age 65 through 69	65% of the under age 65 **death benefit**
Death - age 70 through 74	50% of the under age 65 **death benefit**
Death - age 75 and over	25% of the under age 65 **death benefit**
Accidental Death	Amount equal to **death benefit** shown on certificate face page
Dismemberment - both hands or both feet or sight of both eyes	Amount equal to **death benefit** shown on certificate face page
Dismemberment - one hand and one foot	Amount equal to **death benefit** shown on certificate face page
Dismemberment - one hand and sight of one eye	Amount equal to **death benefit** shown on certificate face page
Dismemberment - one foot and sight of one eye	Amount equal to **death benefit** shown on certificate face page
Dismemberment - sight of one eye	1\2 of **death benefit** shown on certificate face page
Dismemberment - one hand or one foot	1\2 of **death benefit** shown on certificate face page

3. Payment of **benefits** for **covered events** for **dependents** are as follows:

	Amount
Death - **spouse**	50% of **employee death benefit** up to [$5,000]
Death - **dependent** 15 days of age but less than 26 years of age (not a **spouse)**	[$2,000]

SERFF Tracking Number:	*FEMC-127630947*	*State:*	*Arkansas*
Filing Company:	*Federated Life Insurance Company*	*State Tracking Number:*	*49821*
Company Tracking Number:			
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*LIFEPOL2012*		
Project Name/Number:	*LIFEPOL2012/GL 03 10 (01-12 ed.)*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachments:
AR Flesch Score Certification.pdf
Rule 19 Cert_Life.pdf

Item Status: **Status Date:**

Satisfied - Item: Application
Comments:
Attachment:
4420 (01-09).pdf

121 East Park Square
P.O. Box 328 • Owatonna, MN 55060
Phone: (507) 455-5200 • 800-533-0472

FEDERATED LIFE INSURANCE COMPANY

READABILITY CERTIFICATION
for the state of
ARKANSAS

GL 03 10 (01-12 ed.)
GL 03 11 (01-12 ed.)

To the best of my knowledge and belief, these forms meet the Flesch minimum reading ease score of the Arkansas readability requirements with a combined score of 55.2.

2011.09.16
10:39:26 -05'00'

Jeanne H. Hankerson First Vice President

September 16, 2012

121 East Park Square
P.O. Box 328 • Owatonna, MN 55060
Phone: (507) 455-5200 • 800-533-0472

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

FEDERATED LIFE INSURANCE COMPANY

I hereby certify that Federated Life Insurance Company meets the provisions set forth in Rule and Regulation 19 as well as all applicable requirements of the Arkansas Department of Insurance.

Digitally signed by Jeanne Hankerson
Date: 2011.09.27 07:52:14 -05'00'

Signature of Officer

Jeanne H. Hankerson
Name

First Vice President – Director of Compliance
Title and/or Business Affiliation

September 27, 2011
Date

FEDERATED INSURANCE®

Internal use only: Acct #_____

☐ Federated Life Insurance Company
☐ Federated Mutual Insurance Company
Attn: Group Health Administration
1929 S. Cedar, Owatonna, MN 55060
Toll Free: 1-800-377-9154 Fax: 507-446-4697

Employee Enrollment and Record Form

Please print in black ink

Please complete this form carefully. The effective date may be delayed if vital information is missing.

SECTION 1: EMPLOYEE INFORMATION

Employee's Last Name _____ First Name _____ Middle Initial ____ ☐ Single ☐ Married Number of dependent children: _____

Social Security # _____ **Gender** ☐ M ☐ F **Date of Birth** _____ **Height** ____ ft. _____ in **Weight** _____ lbs

Home street address City/State/Zip

Employer's Name City/State/Zip

Job Title	Are you an owner or officer? ☐ Yes ☐ No	**Date employed full-time** (mm/dd/yy):	**Hours worked per week**

Are you (the employee) actively working on a **full-time basis** and receiving a W2 from this employer? ☐ Yes ☐ No

If no longer receiving a wage **from this employer**, what was your last date of employment? (mm/dd/yy) _____ ☐ N/A

How may we contact you if we need more information? Cell Phone ( ) Home phone ( )
Work phone ( ) Best time to call? _____ am/pm (circle one)

SECTION 2: DEPENDENT INFORMATION – *List all dependents applying for coverage*

(Eligible dependents include legal spouse, unmarried children under age 25 or full-time students and disabled children of any age.)

Spouse's Last Name _____ **First Name** _____ **Middle Initial** ____ **Date of Marriage** _____

Social Security # _____ Gender ☐ M ☐ F Date of Birth _____ Height _____ ft. ____in Weight _____ lbs

Dependent Child(ren) Names (First, Middle Initial, Last)	Social Security Number	Date of Birth (mm/dd/yy)	Gender	Relationship to Employee	Resides in your home?
			☐ Male ☐ Female	☐ Natural/adopted child ☐ Stepchild ☐ Other	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Natural/adopted child ☐ Stepchild ☐ Other	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Natural/adopted child ☐ Stepchild ☐ Other	☐ Yes ☐ No
			☐ Male ☐ Female	☐ Natural/adopted child ☐ Stepchild ☐ Other	☐ Yes ☐ No

SECTION 3: BENEFIT SELECTION

(The availability of benefits are based on those offered by your employer)

Select Employee Benefits (Choose One): **AND** **Select Dependent Benefits** (Choose One):

- ☐ All coverages offered by employer
- ☐ Life, Dental, & Short Term Disability Only (if offered)
- ☐ Currently enrolled in COBRA or State Continuation
- ☐ No coverage **(complete Section 4)**

- ☐ Spouse and dependent children
- ☐ Spouse only
- ☐ Dependent children only
- ☐ No coverage **(complete Section 4)**

SECTION 4: DECLINING COVERAGE

(Complete if declining coverage for you, your spouse, or your dependent children)

I am declining health coverage for (check all that apply) ☐ myself ☐ my spouse ☐ my children
because I/we are (choose one) ☐ covered elsewhere. Name of insurer:_____
☐ other Explain: _____

IMPORTANT: DESCRIPTION OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you are otherwise eligible and request enrollment within 30 days after your coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If no additional premium is required for a new dependent, the 30-day enrollment requirement does not apply.

SECTION 5: LIFE INSURANCE BENEFICIARY

(Complete only if applying for life insurance)

Primary Beneficiary:

Legal Name Relationship

Date of Birth Address

Contingent Beneficiary(ies):

Legal Name Relationship

Legal Name Relationship

Continue on Reverse Side →

SECTION 6: HEALTH INFORMATION

(Answer each of the following for **you, your spouse, and each dependent** listed in section 2)

During the *past 5 years*, has any person had, been told they have, or received treatment or follow-up care for:		**Circle all that apply and provide details in Sections 7 and 8**
1. ☐ Yes ☐ No	**Heart/Circulatory**	High Blood Pressure, High Cholesterol, Stroke, Heart Attack, Angioplasty, Aneurysm, Vascular Disease, By-Pass Surgery, Irregular Heart Beat, Heart Valve Problems, Anemia, Blood Disorder, Other
2. ☐ Yes ☐ No	**Lung/Respiratory**	Allergies, Asthma, Cystic Fibrosis, Emphysema, Sleep Apnea, COPD, Other
3. ☐ Yes ☐ No	**Intestinal/Endocrine/ Digestive/Liver**	Diabetes (Type I or II), Hepatitis, Colitis, Ulcerative Colitis, Pancreatitis, Cirrhosis, Diverticulitis Hiatal Hernia, Crohn's Disease, Thyroid Disorder, Other
4. ☐ Yes ☐ No	**Urinary/Kidney**	Kidney Stones, Dialysis, Polycystic Kidneys, Infection, Renal Failure, Enlarged Prostate, Other
5. ☐ Yes ☐ No	**Brain/Nervous**	Multiple Sclerosis, Epilepsy, Seizures, Cerebral Palsy, Paralysis, Brain Injury, Other
6. ☐ Yes ☐ No	**Skeletal/Muscle**	Back/Neck Pain, Hernia, Fibromyalgia, Lupus Muscular Dystrophy, Osteoarthritis, Rheumatoid Arthritis, Joint Replacement, Artificial Limb, Other
7. ☐ Yes ☐ No	**Mental Health**	Anxiety, Depression, Alcohol/Drug Abuse, ADD/ADHD, Bipolar, Anorexia/Bulimia, Other
8. ☐ Yes ☐ No	**Cancer/Tumor/Growth**	Cancer or Tumor (provide location below), Benign Polyp, Hodgkins, Leukemia, Other
9. ☐ Yes ☐ No	**Transplant**	If transplant complete: Organ _____ Date of Transplant _____ If transplant pending: Organ _____ Date Expected _____
10. ☐ Yes ☐ No	Has any person been diagnosed or treated by a physician for AIDS, ARC, or AIDS related condition?	
11a. ☐ Yes ☐ No	Are you or an eligible dependent (even if not enrolling for coverage) an expectant parent? If yes, due date is :_____	
11b. ☐ Yes ☐ No	Are there previous or current complications, previous or current multiple births, or a C-section expected (Circle all that apply & explain in Sections 7 and 8).	
12. ☐ Yes ☐ No	Is any person to be insured currently disabled, hospitalized, on medical leave, or handicapped? (circle all that apply)	
13. ☐ Yes ☐ No	Other than #1-12 above has any person received medical advice or treatment for any condition during the past 5 years? If yes, explain in Sections 7 and 8.	
14. ☐ Yes ☐ No	Is there any medical condition that will require treatment or surgery in the next 24 months on any person to be insured? If yes, explain in Sections 7 and 8.	
15. ☐ Yes ☐ No	Tobacco Use: By whom? Type? Start Date? Stop Date?	
16. ☐ Yes ☐ No	Are any of the above conditions or medications currently covered under Medicare, worker's compensation, auto, or liability coverage? (If yes, circle coverage that applies)	List the condition(s) _____

SECTION 7: Complete for ALL medical conditions circled and/or checked above

(Please use an additional page, if needed)

Question #	Person's Name	Diagnosis (name of injury or illness)	Treatment Received	Date of Onset	Date of full recovery or "Not yet recovered"

SECTION 8: MEDICATIONS: Complete for each person applying for coverage

(List ALL medications taken, use an additional page if needed)

Question #	Person's Name	Medication	Reason Prescribed	# per day	Dosage (mg/gm)	Date first prescribed	Still Prescribed?
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

SECTION 9: EMPLOYEE AUTHORIZATION AND REPRESENTATION

(Read this section, sign, and date this form even if not enrolling for coverage)

A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Agreement: I certify that I have read or have had read to me the completed form and the above answers are, to the best of my knowledge and belief, complete and true and, together with any supplements thereto, shall be the basis for any certificate of insurance issued and that the insurance company may withdraw the coverage for which I am applying and may consider such coverage as having never been in effect, if any information is substantially incomplete or incorrect.

I hereby enroll (or decline to be enrolled) in group insurance plan(s) through Federated Insurance. With my enrollment, I authorize my employer to deduct from my earnings an amount sufficient for my contribution, if any, toward the group insurance premiums.

Employee's Signature	Date Signed	Spouse's Signature (if applying for coverage)	Date Signed
_____	_____	_____	_____

This form MUST be dated and signed

SERFF Tracking Number:	*FEMC-127630947*	*State:*	*Arkansas*
Filing Company:	*Federated Life Insurance Company*	*State Tracking Number:*	*49821*
Company Tracking Number:			
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*LIFEPOL2012*		
Project Name/Number:	*LIFEPOL2012/GL 03 10 (01-12 ed.)*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
09/16/2011	Form	Certificate Cover Page	09/26/2011	GL 03 11 _01-12 ed._.pdf (Superceded)
09/16/2011	Form	Policy Cover Page	09/26/2011	GL 03 10 _01-12 ed._.pdf (Superceded)
09/16/2011	Supporting Document	Flesch Certification	09/27/2011	AR Flesch Score Certification.pdf

FEDERATED LIFE

INSURANCE COMPANY

121 East Park Square ▪ Owatonna, MN 55060

GROUP LIFE INSURANCE CERTIFICATE OF COVERAGE

Employee:
IDN:
Coverage:
Death Benefit
Effective Date:
Employer:
Group No.:

POLICY NUMBER:
POLICYHOLDER:

The **policy** is delivered in Arkansas and is governed by its laws.

The insurance is effective on the date shown above, provided the **employee** meets the eligibility requirements of the **policy**. Only the **dependents** who meet the eligibility requirements of the **policy** are covered by the **policy**. **Dependents** not meeting eligibility are not covered.

The principal provisions of the **policy** are set forth in the following pages. This certificate is not the **policy**. It replaces any other certificate previously issued to the **employee** under the above **policy** number. The terms and conditions of the **policy** control the coverage provided.

Words and phrases appearing in **bold** type throughout the certificate have special meaning as set forth in the Definitions (form GL 03 07).

Executed by Federated Life Insurance Company at Owatonna, Minnesota.

SECRETARY **PRESIDENT**

INDEX

SCHEDULE OF BENEFITS

Section I - GENERAL PROVISIONS . . . . . GL 00 01 (01-12 ed.)

Section II - ENROLLMENT AND EFFECTIVE DATE . . . . . GL 00 02 (01-12 ed.)

Section III - TERMINATION OF COVERAGE . . . . . GL 00 03 (01-12 ed.)

Section IV - EXTENSION OF COVERAGE AND CONVERSION . . . . . GL 00 04 (01-12 ed.)

Section V – COVERED EVENTS. . . . . GL 00 05 (01-12 ed.)

Section VI – EXCLUSIONS . . . . . GL 00 06 (01-12 ed.)

Section VII – DEFINITIONS . . . . . GL 03 07 (01-12 ed.)

Section VIII - GRIEVANCE AND APPEAL PROCEDURES . . . . . GL 00 08 (01-12 ed.)

FEDERATED LIFE

INSURANCE COMPANY
HOME OFFICE: 121 East Park Square, Owatonna, Minnesota 55060
Phone: 800-533-0472

GROUP LIFE POLICY

Policyholder: _____

_____

_____

Policy Effective Date: _____
at 12:01 a.m. Central Standard Time

Policy Anniversary: _____ and annually each year thereafter.

Policy Number: _____

This policy is delivered in Arkansas and is governed by its laws.

CONSIDERATION. The **policy** is issued to the **policyholder** in consideration of the application and payment of premiums.

Secretary President

INDEX

SCHEDULE OF BENEFITS

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